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Client Health Record Policy

Document Information	
Document Title:	Client Health Record Policy
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Category:	Client Health Record
Approval for use details:	**Authored by: Continuous Quality Improvement Coordinator** **Approved by: Board** **Date approved for use: March 2023** **Date due for internal review: March 2026**
Purpose:	To ensure staff can refer to a policy and procedure around the entering, storage and management of client health information.
Related Policies and Procedure/s:	Archiving Medical Records and Inactive Clients Policy
Related Form / Document:	
Key Word/s:	Communicare, MHR, client health record, patient, Client health records, medical records, Communicare, patient information
External References:	Northern Territory Remote Health Atlas
Document Modification History:	1) Reviewed by the Primary Health Care Clinical Governance Group 2013 2) Reviewed by PHCG and reapproved for use, 22 June 2016 3) Reviewed and approved by PHCG – August 2019 4) Reviewed and interim CEO approval – February 2023 5) Approved by Board – March 2023

Background

KWHB use Communicare, an electronic Clinical Information System. It is health service policy that all client information and consults are recorded in Communicare.

KWHB client health records are a detailed, confidential document compiled by a health professional over a period for each individual client.

Its primary purpose is to:

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- Identify a person accurately
- Record symptoms and signs
- Support diagnoses
- Justify management decisions

Each client has their own individual file. This record contains:

- All clinical information relating to the client
- Contact and demographic information including the client's full name, date of birth, gender, address and contact details
- Self-identified cultural background (e.g., Aboriginal and/or Torres Strait Islander)
- The client's preferred contact in an emergency

Principles

1.	Provision of well-designed, high-quality care
2.	Provision of care that is relevant and supportive
3.	Provision of care that is safe and that is client focused
4.	Provision of a safe and healthy work environment

Procedures

1) It is KWHB policy that all active clients have a client record that contains a health summary including:

- Medical alerts and adverse reactions (including allergies)
- Current medicines list
- Current health problems
- Significant past medical history
- Risk factors (SNAPE)
- Immunisations

- Relevant family history
- Relevant social history

2) All KWHB client records need to have:
   - A record of allergies in the health summary, which is reviewed regularly
   - All significant face-to-face, telephone or electronic communication recorded in the progress notes
   - Health records updated to show recent important events including immunisations, medications, births and family history changes
   - All hard copies of client investigations (e.g. ECGs, echos) that can't be scanned are kept in a hard copy file on site
   - Where appropriate, paper-based records will be scanned into the electronic clinical record
3) Active health records are considered to be records of a client who has attended our health service in the past two years. See the Archiving Medical Records and Inactive Client Policy for definitions of client types.

Consultation notes

1) It is a KWHB requirement that all consultations are documented including those outside normal opening hours, home or other visits and clinically significant telephone consultations. Consultation notes must include the following:
   - Date of consultation
   - Reason for consultation
   - Relevant clinical findings
   - Diagnosis
   - Recommended management plan and where appropriate expected process of review
   - All medication administered or supplied (including medicine name, strength, directions for use/dose frequency, number of repeats, and date medicine started/ceased/changed)
   - Any relevant preventive care undertaken
   - Documentation of referral to other health care providers or health service;

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- Any special advice or other instructions
- Identification of who conducted the consultation, e.g., by initial in the notes, or audit trail in electronic record
- Evidence that problems raised in previous consultations are followed up

2) Progress notes should be documented in the SOAP format
   - S subjective (history, the patient's story)
   - O objective (examination findings)
   - A assessment (diagnosis or impression)
   - P plan (treatment, follow-up)
3) Client health records must show evidence that problems raised in previous consultations are followed up.
4) Communicare client records are held at an off-site interstate location, and automated backups are made in the event of system failure. Every 24 hours, at 12am EST, the Communicare record is closed. Any staff member accessing Communicare at that time will need to log in again, and any unsaved portion of an open clinical record may be lost.
5) In the case of local power/ internet connectivity failure, another KWHB health centre or the My e Health Record may be able to supply client information in an emergency.